Contract Amendment for BadgerCare Plus and SSI Medicaid Services

The agreement entered into for the period of February 1, 2008 through December 31, 2009 between the State of Wisconsin acting by or through the Department of Health Services, herein after referred to as the "Department" and _____, an insurer with a certificate of authority to do business in Wisconsin for the BadgerCare Plus and/or Medicaid SSI Medicaid Managed Care Program is hereby amended.

1. This amendment is effective on the first day of the month in which the Department makes a payment to the HMO under Article VI, K.

2. The table of contents is updated to reflect this amendment.

3. Article VI, K is amended to read as follows:

K. Hospital Access Payment

Within the limits of the budgeted allocation from the hospital assessment fund, the Department will pay the HMO a monthly hospital inpatient access payment and a monthly hospital outpatient access payment. The Department's monthly hospital access payments to the HMOs are made as prospective "per member per month" payments, unadjusted for CDPS and rate region realignment.

Within 15 calendar days after receipt of the monthly amounts, the HMO shall make payments to eligible hospitals based on the number of qualifying discharges and visits in the previous month. These payments are in addition to any amount the HMO is required by agreement to pay the hospital for provision of services to HMO members.

An "eligible hospital" means a Wisconsin hospital that is not a critical access hospital, an institution for mental disease, or a general psychiatric hospital for which the Department has issued a certificate of approval that applies only to the psychiatric hospital and that is not a satellite of an acute care hospital. A list of qualifying hospitals is available from the Department upon request.

"Qualifying discharges and visits" are inpatient discharges and outpatient visits for which the HMO made payments in the month preceding the Department's monthly access payment to the HMO for services to the HMO's Medicaid and BadgerCare Plus members, other than Core Plan members or members who are eligible for both Medicaid and Medicare. HMOs shall exclude all members who are dually-eligible and all dual-eligible claims. If a third party pays the claim in full, and the HMO does not make a payment, the claim shall not count as a qualifying claim for the hospital access payment. If the HMO pays any part of the claim, even if there is a third party payer, the claim will be counted as a qualifying claim for the hospital access payment.

1. Method of payment to hospitals

a. Within 15 calendar days of receiving the hospital access payments from the Department, the HMO shall provide payments to eligible hospitals. The HMO shall pay out the full amounts of hospital access payments. The HMO will base its hospital payments upon the number of qualifying discharges and the number of qualifying visits regardless of the amount of the base claims payment for those discharges and visits. The HMO shall pay each eligible hospital based upon its percentage of the total number of qualifying discharges and the total number of qualifying visits for all eligible hospitals. The HMO shall calculate the percentage of the total access payment that each hospital would receive to the fourth decimal point.

b. An example of the payment methodology is as follows:

HMO A receives $1 million for inpatient access payments and $500,000 for outpatient access payments in the month of June. HMO A distributes inpatient and outpatient access payments to eligible hospitals received from the Department in June according to the following formula:

1. Inpatient: HMO A counts 1,000 inpatient qualifying discharges paid in May (excluding Medicare crossover claims) to three eligible hospitals.

   Hospital X was paid for 300 discharges by HMO A in the month of May, and therefore, will receive 30% of the total inpatient access payment HMO A received from the Department in June.

2. Outpatient: HMO A counts 2,000 outpatient qualifying visits paid in May (excluding Medicare crossover claims) to five eligible hospitals.

   Hospital X was paid for 400 visits by HMO A in the month of May, and therefore, will receive 20% of the total outpatient access payment HMO A received from the Department in June.

2. Payment of SFY09 base hospital rates

For HMOs, any reference made to the "FFS rate schedule" in HMO-hospital contracts that is meant to be used as the basis of HMO DRG payments for dates of service and discharges from July 1, 2008 through June 30, 2009 will be the SFY08 FFS hospital DRG rates.

3. Monthly reporting requirements

a. The HMO shall send a report along with its monthly payment to each eligible hospital that contains the following information:
   1. The amount of the hospital access payments received from the Department for inpatient discharges;

2. The amount of the hospital access payments received from the Department for outpatient discharges;
3. That hospital's number of qualifying inpatient discharges;
4. That hospital's number of qualifying outpatient visits;
5. The total number of qualifying inpatient discharges for all qualifying hospitals;
6. The total number of qualifying outpatient visits;
7. Access payment amount per qualifying inpatient discharge
8. Access payment amount per qualifying outpatient visit;
9. The amount of the total payment to that hospital.

b. Within 20 calendar days of receipt of payment from the Department, the HMO must submit the report in Addendum IV, K to the Department.

4. Noncompliance

The Department shall have the right to audit any records of the HMO to determine if the HMO has complied with the requirements in this section K. If at any time the Department determines that the HMO has not complied with any requirement in this section K, the Department will issue an order to the HMO that it comply and the HMO shall comply within 15 calendar days after the Department's determination of noncompliance. If the HMO fails to comply after an order, the Department may terminate the contract as provided under Article XII.

Upon request, the HMO must submit a list of paid inpatient and outpatient claims to the Department and any other records the Department deems necessary to determine compliance.

5. Payment disputes

If the HMO or the hospital dispute the monthly amount that the HMO is required to pay the hospital, either party may request that the Department determine the amount of the payment if the request is filed within six months after the first day of the month in which the payment is due. The Department will determine the amount of the payment within 60 days after the request for a determination is made. The HMO or hospital may request a contested case hearing under Ch. 227 on the Department's determination.

6. Resolution of Reporting Errors

The HMO shall adjust prior hospital access payments that were based on an inaccurate counting of qualifying inpatient discharges or outpatient visits. If an error is discovered, the adjustment will be applied on a prospective basis. Errors shall be corrected in the next distribution of the monthly access payments the HMO receives from DHS.

Inpatient discharges and outpatient visits that were excluded in error shall be added into the calculation for the distribution of the next monthly access payments the HMO receives from DHS.

Discharges and visits that were included in error in previous payments shall be corrected in the next distribution of the monthly access payments the HMO receives from DHS. The number of discharges and visits paid in error will be subtracted from the number of discharges and visits eligible for payment in the current payment month. If there are insufficient numbers of discharges or visits in the current payment month to offset the error, the remaining uncorrected discharges or visits shall be carried forward and corrected in the next payment month.

4. Article VII, I is amended to read as follows:

I. Contract Specified Reports and Due Dates

2009 REPORTS AND DUE DATES

Type of Report	**Frequency**	**Report Period**	**Reporting Unit**	**Report Format**
Encounter Data File	Monthly, on 10th	Previous Month	Fiscal Agent	Electronic Media
HMO Provider and Facility Network	On 20th of every month, or for significant changes	Next month	DHS	Electronic Media
Dental Progress Report **	Quarterly	Previous Quarter	BBM	Hardcopy
Assessment Report	Monthly, on 20th	Previous Month	Enrollment Specialist	Electronic Media
Formal/Informal Grievance Experience Summary Report	Quarterly (within 30 days of end of quarter)	Previous Quarter	BBM	Hardcopy
Attestation Form	Quarterly	Previous Quarter	BBM	Hardcopy
Common Carrier Data	Quarterly	Previous Quarter	BFM – Rate Section	CD-Rom
AIDS/Ventilator Dependent Report	Quarterly	DOS prior to January 1, 2009	BFM	CD-Rom & Hardcopy
Federally Qualified Health Centers & Rural Health	February 15	Annual	BBM	Hardcopy – no form

Centers				
Coordination of Benefits Report	Quarterly (within 45 days of end of quarter)	Previous Quarter	BBM	Electronic Media
Neonatal ICU Patient Care Data	April 1	Annual	BFM	Hardcopy
Initial Performance Improvement Project Topic Selection Summary	First business day of January	Annual	BBM & EQRO	Electronic Media
Member Communication and Outreach Plan	Second Friday of January	Annual	BBM	Electronic Media
High-risk Pregnancy Plan	First business day of April	Annual	BBM	Electronic Media
Performance Improvement Project Final Report	First business day of December	Annual	BBM & EQRO	Electronic Media
Individual Hospital Access Payment Data	Monthly, at the time of access payment (15 calendar days of receiving payment from DHS)	Previous month	Any hospital the HMO made payments to	As determined by hospital contract
Summary Hospital Access Payment Report (Art. IV, K)	Monthly, within 20 calendar days of receiving payment from DHS	Previous month	BFM	Electronically

Any reports that are due on a weekend or holiday are due the following business day.

** Only the HMO that is certified to provide dental services is required to submit dental progress reports for the service area in which the HMO is certified to provide dental.

BBM = Bureau of Benefits Management

BFM = Bureau of Fiscal Management

Report Mailing Addresses:	Department of Health Services Bureau of Benefits Management P.O. Box 309 Madison, WI 53701-0309	Fiscal Agent Managed Care Unit P.O. Box 6470 Madison, WI 53716-0470	Department of Health Services Affirmative Action/Civil Rights Compliance Office P.O. Box 7850 Madison, WI 53707-7850

5. Addendum IV, K is created to read as follows:

K. Summary Hospital Access Payment Report to Department of Health Services

This report will be provided to the HMO electronically for completion. Within 20 calendar days of receiving the access payment from the Department, HMOs must submit to the Department the following information for each paid hospital:

HMO Name	
Month, Year payment was received from the Department	
Month, Year from which hospital discharge and visit data is being reported (i.e. previous month)	
*** Grand Total Payment**	

* Total payments made to all hospitals should be equal to the total amount the HMO received from the Department. The distribution of these funds by the HMO to hospitals shall be based on eligible discharges and visits in the prior month paid by the HMO to eligible hospitals.

1	2	3	4	5	6	7	8	9	10	11
Hospital Name	**Inpatient Funding Received from DHS**	**Number of Hospital Qualifying Inpatient Discharges Paid to the Individual Hospital**	**Number of Total Inpatient Discharges Paid by HMO to All Eligible Hospitals**	**Percent of the Hospital's Total Inpatient Discharges Paid by the HMO (Column 3 / Column 4)**	**Payment to Hospital for Inpatient Discharges (Column 2 x Column 5)**	**Outpatient Funding Received from DHS**	**Number of Hospital Qualifying Outpatient Visits Paid to the Individual Hospital**	**Number of Total Outpatient Discharges Paid by HMO to All Eligible Hospitals**	**Percent of the Hospital's Total Outpatient Visits Paid by HMO (Column 7 / Column 8)**	**Payment to Hospital for Outpatient Visits (Column 7 x Column 10)**
Total:										

I hereby attest and affirm that the information being submitted is complete, factual and correct to the best of my knowledge. I furthermore attest and affirm that no material facts have been omitted from this form. I understand that payment and satisfaction of this/these claim(s) will be from federal and state public funds and that I may be prosecuted under applicable federal and state laws for any false claims, statements, or documents, or concealment of a material fact. I furthermore understand that state or federal authorities may inspect all claims, records or documents pertaining to the provision of these services.

_____ _____

(Signature) (Date)

6. Exhibit II is created to read as follows:

Wisconsin Department of Health Services
2009 MCE and Capitation Rate Development for the BadgerCare Plus Standard and Benchmark Programs
Capitation Rate Increase for Hospital Access Payments

Existing HMOs

HMO	January - June	July - December
Abri	$ 126.20	$ 65.26
CCHP	124.47	63.74
CompCare	50.20	26.56
Dean	94.19	49.73
Dean Southeast	124.73	63.86
GHC-SCW	84.76	43.68
GHC-EC	65.35	34.60
Health Tradition	72.67	38.59
MercyCare	112.53	57.56
MHS	112.36	57.63
Network	112.07	57.90
Security	86.80	45.70
UHC	124.32	63.76
Unity	141.76	71.91

New HMOs

Region	January - June	July - December
1	$ 53.60	$ 28.30
2	113.43	58.57
3	84.48	44.54
4	110.05	56.84
5	130.75	66.81
6	119.46	61.28

Wisconsin Department of Health Services

2009 MCE and Capitation Rate Development for the SSI Program

Capitation Rate Increase for Hospital Access Payments

Existing HMOs

HMO	January - June	July - December
Abri	$ 259.29	$ 134.33
I - Care	376.83	192.04
MHS	295.87	151.22
NHP	260.44	133.11
UHC	318.50	162.77

New HMOs

Region	January - June	July - December
1	$ 325.52	$ 166.32
2	325.52	166.32
3	325.52	166.32
4	325.52	166.32
5	325.52	166.32
6	325.52	166.32

All terms and conditions of the February 1, 2008 through December 31, 2009 contract and any prior amendments that are not affected by this amendment shall remain in full force and effect.

HMO Name	**Department of Health Services**
Official Signature	Official Signature
Printed Name	Printed Name Jason Helgerson
Title	Title Medicaid Director Division of Health Care Access and Accountability
Date	Date